Calendar No. 607

108TH CONGRESS
2d Session
SENATE
REPORT
108–291

EMERGENCY MEDICAL SERVICES SUPPORT ACT

R E P O R T

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 2351

TO ESTABLISH A FEDERAL INTERAGENCY COMMITTEE ON EMERGENCY MEDICAL SERVICES AND A FEDERAL INTERAGENCY COMMITTEE ON EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL, AND FOR OTHER PURPOSES

JUNE 30, 2004.—Ordered to be printed

Filed, under authority of the order of the Senate of June 25, 2004

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Ms. COLLINS, from the Committee on Governmental Affairs, submitted the following

R E P O R T

[To accompany S. 2351]

The Committee on Governmental Affairs, to whom was referred the bill (S. 2351) to establish a Federal Interagency Committee on Emergency Medical Services and a Federal Interagency Committee on Emergency Medical Services Advisory Council, and for other purposes, having considered the same reports favorably thereon and recommends that the bill do pass.

CONTENTS

I. PURPOSE AND SUMMARY

The Senate Governmental Affairs Committee (the Committee) approved S. 2351, the Emergency Medical Services Support Act, on June 2, 2004. This legislation would formally establish the Federal Interagency Committee on Emergency Medical Services (FICEMS) to enhance coordination among a number of federal agencies and maximize the best use of funding for emergency medical services. This legislation would also establish a FICEMS Advisory Council, which would create a mechanism for individuals at the state and

local levels to provide input into how Federal emergency medical service (EMS) programs should be coordinated.

II. BACKGROUND

For the past 20 years, Federal support for EMS has been both scarce and uncoordinated. Since the last major Federal EMS infrastructure investment, the Emergency Services Systems Act of 1973 (Pub. L. 93–154, repealed on August 13, 1981, by Pub. L. 97–35), support for EMS has been spread among a number of agencies, including the Department of Transportation's National Highway Traffic Safety Administration (NHTSA), the Department of Health and Human Services' Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Department of Homeland Security's Emergency Preparedness and Response Directorate, the United States Fire Administration, the Office for Domestic Preparedness, and the Centers for Medicare and Medicaid Services. Most of the support offered by these agencies has focused only on specific system functions, rather than on overall system capacity, and has been inconsistent and ineffectively coordinated.

In 2001, at the request of Senators Collins and Feingold, the General Accounting Office (GAO) completed its report, ''Emergency Medical Response: Reported Needs Are Wide-Ranging, With Lack of Data A Growing Concern,'' (GAO–02–28) which illustrated the need to increase coordination among Federal agencies as they address the needs of regional, state, or local emergency medical services systems. According to GAO, these needs, including personnel, training, and equipment, vary between urban and rural communities.

The Committee believes that the need for Federal support and coordination is especially critical with the increasing burden placed on state and local EMS systems by homeland defense and security issues. In a mass casualty event, communities rely on their EMS system to provide front line medical care for the first 12 to 24 hours, before Federal resources become available. Yet many local systems lack the skills and resources needed to detect, respond to, and manage mass casualty incidents. Without adequate preparation, local systems are likely to become quickly incapacitated, leaving the community with no EMS coverage for even routine emergencies such as motor vehicle crashes and cardiac arrests.

EMS systems also require substantial development to realize their potential as key elements of our communities' emergency medical safety nets. A number of sources of information are available to identify specific strengths and weaknesses in EMS systems. These include the Statewide EMS Assessments conducted by NHTSA in 48 States between 1988–2001, the 1996 EMS Agenda for the Future, a survey of State EMS Directors conducted in 2000 by the Office of Rural Health Policy in the Department of Health and Human Services, and a 2001 General Accounting Office Report on Emergency Medical Response.

These sources consistently indicate shortcomings in EMS systems in several critical areas, including emergency communications, trauma system development, EMS information systems, and rural EMS. EMS communications systems are a particular weak point. For example, no state has yet fully implemented wireless

E9–1–1, a shortcoming that prevents emergency responders from automatically locating people who call 9–1–1 from wireless phones. Communication among emergency providers is also lacking, especially in rural areas where nearly three quarters of EMS systems lack the ability to reliably communicate among dispatchers, ambulances, and hospitals.

Trauma system development is critically needed, with 61 percent of States lacking triage protocols for transporting patients to specialty care facilities, such as trauma centers, burn centers, and pediatric centers. EMS information systems are another weakness, with over 90 percent of States lacking critical components of the comprehensive data systems needed to efficiently manage EMS resources, respond to daily emergencies, and provide adequate surveillance to detect acts of terrorism such as chemical, nuclear, or biological events. Other shortcomings identified by these studies include EMS medical direction, recruitment and retention of EMS personnel, and EMS research.

This legislation would enhance support for EMS, 9–1–1 systems, and improve emergency response capacity nationwide by formally establishing a Federal Interagency Committee on Emergency Medical Services (FICEMS), which is currently an ad-hoc committee with insufficient formal direction. FICEMS would enhance coordination among the federal agencies involved with the state, local, tribal and regional emergency medical services and 9–1–1 systems. Improved coordination would also maximize the use of established funding. FICEMS activities would include preparing an annual report to Congress on the Committee's activities, actions, and recommendations.

The President has also recognized the need for this coordination. He included a similar proposal in his reauthorization proposal for the "Safe, Accountable, Flexible, and Efficient Transportation Equity Act of 2003" (SAFETEA) that was transmitted by Secretary Mineta to Congress on May 12, 2003. The Senate-passed Transportation legislation, the Safe, Accountable, Flexible, and Efficient Transportation Equity Act of 2003 (S. 1072), also includes a similar proposal.

S. 2351 builds upon the Administration's proposal by creating a more effective structure and incorporating the input of local EMS providers into federal EMS programs. Most significantly, this legislation creates a FICEMS Advisory Council, which establishes a mechanism for individuals at the state and local levels to provide input regarding how Federal EMS programs should be coordinated. The FICEMS Advisory Council established under this legislation would consist of 13 individuals with interest or expertise in emergency medical services and would be selected by FICEMS. The Advisory Council would also review FICEMS' annual report summarizing its activities, actions, and recommendations.

The Advisory Council would also assist FICEMS in its ongoing mission, which includes activities to:

(1) Ensure coordination among the Federal agencies involved with State, local, Tribal, or regional emergency medical services and 9–1–1 systems;

(2) Ensure that emergency medical services are appropriately integrated with homeland security and other emergency response programs;

(3) Identify State, local, Tribal, or regional emergency services and 9–1–1 system needs;

(4) Recommend new or expanded programs, including grant programs, for improving State, local, Tribal, or regional emergency medical services and implementing improved EMS technologies, including wireless E9–1–1;

(5) Identify ways to streamline the process through which Federal agencies support State, local, Tribal, or regional emergency medical services; and

(6) Assist State, local, Tribal, or regional emergency medical services in setting priorities based on identified needs.

A wide range of organizations representing State and local EMS stakeholders have identified the need for this legislation. The Advocates for EMS, the American Ambulance Association, the American Heart Association, the Association of Air Medical Services, the Emergency Nurses Association, the National Association of Emergency Medical Services Educators, the National Association of Emergency Medical Services Physicians, the National Association of Emergency Medical Technicians, the National Association of State Emergency Medical Services Directors, and the National Registry of Emergency Medical Technicians have all urged Congress to enact S. 2351 as soon as possible.

III. LEGISLATIVE HISTORY

S. 2351 was introduced on April 27, 2004 by Senator Susan Collins and Senator Russell Feingold and was referred to the Committee on Governmental Affairs. The Senate Governmental Affairs Committee met on June 2, 2004 and by voice vote approved S. 2351 without amendment. Senators present: Voinovich, Bennett, Fitzgerald, Lieberman, Levin, Akaka, Carper, Lautenberg, and Collins.

IV. SECTION BY SECTION

Section 1 states S. 2351's title, the Emergency Medical Services Support Act.

Section 2 of this legislation would establish the Federal Interagency Committee on Emergency Medical Services. Subparagraph (a) would direct the Secretary of Transportation and the Secretary of Homeland Security through the Under Secretary for Emergency Preparedness and Response, in consultation with the Secretary of Health and Human Services, to establish a Federal Interagency Committee on Emergency Medical Services to provide intergovernmental coordination of emergency medical services.

Subparagraph (b) establishes the Interagency Committee's membership which would consist of the following officials, or their designees: NHTSA Administrator; Director, Office for Domestic Preparedness, Department of Homeland Security; Administrator of the Health Resources and Services Administration, HHS; Director of the Centers for Disease Control and Prevention; Administrator of United States Fire Administration, Emergency Preparedness and Response Directorate, Department of Homeland Security; Director of the Center for Medicare and Medicaid Services; Under Secretary of Defense for Personnel and Readiness, Department of Defense; Assistant Secretary for Public Health Emergency Preparedness, Department of Health and Human Services; Director, Indian

Health Service, Department of Health and Human Services; Chief, Wireless Telecom Bureau of the Federal Communications Commission; and representatives of any other Federal agency identified by the Secretary of Transportation or the Secretary of Homeland Security through the Under Secretary for Emergency Preparedness and Response, in consultation with the Secretary of Health and Human Services, as having a significant role in relation to the purposes of the Interagency Committee on EMS.

Subparagraph (c) would require FICEMS members to annually select a Chairperson of the Committee.

Subparagraph (d) would require the Committee to (1) ensure coordination among the Federal agencies involved with State, local, Tribal, or regional emergency medical services and 9–1–1 systems; (2) identify State, local, Tribal, or regional emergency services and 9–1–1 system needs; (3) ensure that emergency medical services are appropriately integrated with homeland security and other emergency response programs; (4) recommend new or expanded programs, including grant programs, for improving State, local, Tribal, or regional emergency medical services and implementing improved EMS technologies, including wireless E9–1–1; (5) identify ways to streamline the process through which Federal agencies support State, local, Tribal, or regional emergency medical services; (6) assist State, local, Tribal, or regional emergency medical services in setting priorities based on identified needs; and (7) advise, consult with, and make recommendations on matters relating to the implementation of the coordinated with emergency medical services programs.

Subparagraph (e) would require FICEMS to meet as frequently as is determined necessary by the chairperson, but no less frequently than quarterly.

Subparagraph (f) would require NHTSA, in cooperation with the Director, Office for Domestic Preparedness, Department of Homeland Security, to provide administrative support to the Committee, including scheduling meetings, setting agendas, keeping minutes and records, and producing reports.

Subparagraph (g) would require FICEMS to prepare an annual report to Congress on the Committee's activities, actions, and recommendations.

Section 3 would establish a FICEMS Advisory Council (the Advisory Council). Subparagraph (a) would require the Advisory Council to consist of not more than 13 individuals with an interest or expertise in emergency services. Subparagraph (b) would require the Advisory Council's members to represent both rural and urban areas. Subparagraph (c) would require the members of the Advisory Council to annually select an individual from among the members of the Council to serve as chairperson.

Subparagraph (d) would require the Advisory Council to make recommendations regarding: (1) Improved coordination and support of EMS systems among the federal programs; (2) Development of a national EMS plan: (3) Standards, guidelines, benchmarks, and data collection; (4) Guidelines for conducting needs assessments for improving community-based emergency medical services systems at State and local levels; (5) Creation of new or expansion of existing grants or other programs for improving community-based emergency medical services; (6) Consolidation or realignment of Federal

agency or program responsibility for emergency medical services; (7) Strengthening EMS systems through enhanced workforce development, education, training, exercises, equipment, medical oversight, and other areas; and (8) Issues or topics to be addressed in the annual report of the Interagency Committee, review the annual report of the Interagency Committee, and include independent information or recommendations for inclusion in the report as deemed appropriate by the Advisory Council.

Subparagraph (e) would require the Advisory Council to review the Interagency Committee's annual report before its submission to Congress. Subparagraph (f) would require the Advisory Council to meet at the same time and place as the Interagency Committee on EMS and conduct independent meetings to receive public comment and collect data and information. Subparagraph (g) establishes that the members of the Advisory Council shall receive no pay by reason of their service on the Advisory Council, but shall be allowed travel expenses, including per diem in lieu of subsistence at rates authorized under subchapter 1 of chapter 57 of title 5, United States Code. Subparagraph (h) would direct the Administrator of NHTSA, in cooperation with the Director of the Office for Domestic Preparedness of the Department of Homeland Security to provide administrative support to the Advisory Council.

V. EVALUATION OF REGULATORY IMPACT

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has considered the regulatory impact of this bill. CBO states that there are no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and no costs on State, local, or tribal governments. The legislation contains no other regulatory impact.

VI. CBO COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 14, 2004.

Hon. SUSAN M. COLLINS,
Chairman, Committee on Governmental Affairs,
U.S. Senate, Washington, DC.

DEAR MADAM CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2351, the Emergency Medical Services Support Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Rachel Milberg.

Sincerely,

ELIZABETH M. ROBINSON
(For Douglas Holtz-Eakin, Director).

Enclosure.

S. 2351—Emergency Medical Services Support Act

S. 2351 would direct the Secretary of Transportation and the Secretary of Homeland Security to establish a Federal Interagency Committee on Emergency Medical Services. This committee would improve coordination among federal programs related to emergency medical services, recommend new programs or expansions to exist-

ing programs in order to meet the needs of state and local governments, and submit a report to the Congress each year on the committee's activities.

Assuming appropriation of the necessary amounts, CBO estimates that implementing the bill would cost about $1 million each year beginning in fiscal year 2005. This estimate is based on the cost of similar commissions. Enacting the bill would not affect direct spending or revenues.

S. 2351 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

The CBO staff contact for this estimate is Rachel Milberg. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VII. CHANGES TO EXISTING LAW

S. 2351 is a freestanding provision of law that does not amend existing law.

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